STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 87587-001**

v

Paramount Care of Michigan, Inc.
Respondent
_____/

Issued and entered
This 21st day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 4, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On February 11, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

This matter can be resolved by applying the terms of coverage as defined in the Paramount Care of Michigan, Inc. certificate of coverage (Certificate). It is not necessary to obtain a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

On September 7, 2007, the Petitioner's primary care physician submitted to Paramount a request for Petitioner to see Dr. XXXXX, a reproductive endocrinologist. The purpose of the consultation was to develop a treatment plan for Petitioner's endometriosis. Dr. XXXXX is not in the Paramount provider network. Paramount denied authorization.

Following the Petitioner's appeal, Paramount issued a final adverse determination letter dated September 24, 2007. (The final adverse determination letter was postmarked December 3, 2007. Based on the postmark, Petitioner's request for external review was filed in a timely manner.)

III
ISSUE

Did Paramount properly deny coverage for the Petitioner's request for out-of-plan services?

IV
ANALYSIS

Petitioner's Argument

Petitioner's primary care physician made a request to Paramount for a referral to Dr. XXXXX because Dr. XXXXX has performed surgery on Petitioner in the past and has followed her care for approximately the last 13 years. Petitioner says Dr. XXXXX is most familiar with her case and is the one who originally prescribed Lupron for her condition. She made the request because in August 2007, she began having problems believed to be related to her use of Lupron in the treatment of her endometriosis. She spoke with her gynecologist who directed her back to the original doctor who prescribed the medication. She also saw a network endocrinologist who advised her to seek treatment with a reproductive endocrinologist. Paramount approved a consultation with two in-network reproductive endocrinologists in XXXXX, XXXXX but, Petitioner says, they primarily treat infertility, not her specific problem.

Petitioner's network endocrinologist does not believe Petitioner should have to go to Ohio for treatment. In addition, she notes that her denial was based on a review by a family medicine physician. She says although this physician may have some experience with her condition, that person does not specialize in the treatment of endometriosis. Therefore, she is asking that Paramount let her return to Dr. XXXXX or allow her to see an in-network reproductive endocrinologist located in Michigan with interest in endometriosis. She also wants

the physician located in Michigan because she believes that she may soon need surgery and does not want to have to make several trips to XXXXX for care. She believes it would be difficult to receive post-surgical care, and would be burdensome to have another individual drive her back and forth to XXXXX for follow-up.

Finally, Petitioner says that with the state of Michigan's economy she would rather support a Michigan business.

Respondent's Argument

In its final adverse determination, Paramount stated that its decision is to

> uphold the original denial for the out-of-plan referral as there are reproductive endocrinologists available in plan. Since the services are available by participating providers, the out-of-plan referral could not be authorized. Please see pages 13 and 14 of the Subscriber Certificate/Member Handbook which states that Paramount will only approve an out-of-plan specialist referral when the service is not available from any participating Providers.

Commissioner's Review

The Paramount Subscriber Certificate/Member Handbook, pages 13-14, describes Special Referrals and includes the following provision:

> If a medically necessary covered service is not available from any Participating Providers, Paramount will make arrangements for an out of plan referral. Referral and consultations with Participating specialists will be required before an out of plan referral can be considered. Your Primary Care physician must request an out of plan referral in advance. If Paramount approves the out of plan referral, written authorization will be covered subject to appropriate Copayments.
>
> If you have a condition that requires continuing specialty care, you may request a standing referral to a participating specialist from your Primary Care physician. Your Primary Care Physician will consult with your Specialist regarding a plan of treatment. The specialist will send regular consultation reports to keep your Primary Care Physician advised of your progress. The Primary Care Physician may authorize the referral for up to a twelve (12) month period. Once this has been approved, you will receive a "Referral Confirmation". If further services are required beyond the twelve (12) month period, you, your Primary Care Physician and the Specialist will agree to a new treatment plan.

The Petitioner has given a reasonable explanation for why she wants to see Dr. XXXXX. However, Paramount has reproductive endocrinologists in its network and, under the terms of coverage, services from out-of-plan providers are only covered when in-network care is not available. The Paramount network reproductive endocrinologist providers are able to provide medically necessary services for the Petitioner. Petitioner lives in XXXXX, Michigan. The Paramount network specialists are in XXXXX. Traveling distance is approximately 50 miles. The specialist Petitioner prefers is in XXXXX, Michigan, 22 miles from Petitioner's home. Although the providers may be located in XXXXX, they are not an unreasonable distance from the Petitioner's home and are located within Paramount's service area.

The Commissioner finds that Paramount's determination of benefits was appropriate and it is not required to provide coverage for a consultation or treatment by Dr. XXXXX.

V
ORDER

Paramount's September 24, 2007, final adverse determination is upheld. Paramount is not required to provide coverage for care from an out of plan provider.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.